Quality Assessment and Performance Improvement Program

Annual Evaluation

2023

CQMC: 2/20/2024

HAP CareSource
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Introduction

The HAP CareSource Quality Program is supported by the Quality Management Department, the Clinical Quality Management Committee (CQMC) and its subcommittees, the HAP CareSource Board of Directors and HAP staff at large. During the calendar year 2023, HAP CareSource continued to work on making improvements in quality care for the well-being and safety of members. As of December 2023, HAP CareSource Medicaid membership was 32,981. This Program Evaluation is applicable to Medicaid unless otherwise noted. Effective 10/1/23, HAP Empowered officially changed its corporate name to HAP CareSource. This change signifies that the HAP CareSource health plan will be jointly administered by Health Alliance Plan of Michigan and CareSource.

Highlights of the 2023 Quality Assessment and Performance Improvement Program All-Product (QAPI) includes the following achievements and organizational accomplishments:

- Successful completion of NCQA® MED Module and LTSS Distinction
- HAP has ranked #1 in Member Satisfaction among Commercial Health Plans in Michigan, according to the J.D. Power 2023 Commercial Member Health Plan study.
- HAP partnered with the Detroit Public Schools Community District (DPSCD) to support a program that provides coats and personal care items to students throughout the district who need them. HAP's $75,000 donation to the DPSCD Foundation will purchase all-weather coats and personal care items that students can "shop" for at DPSCD schools. The program is designed to support students and their families, eliminating barriers to attendance and attention while at school.
- HAP installed washers and dryers in three of the schools in Q1 2023
- OneSight Clinic and Health Fair – HAP has brought OneSight again to Grace Community Church – 218 pairs of glasses were dispensed at the clinic onsite, 88% of individuals seen needed glasses. Wayne Mobile Health completed 32 health screenings, 48 BP screenings, Kare Mobile and Covenant Community Care completed 35 dental cleanings and Nation's Benefits completed 25 hearing screenings
- Hunger Action Month - Food Bank of Eastern Michigan – HAP is the presenting sponsor of activities with the Food Bank scheduled in the month of September
    - Promoting $5000 matching gift challenge - $10,000 total
    - Social media post with healthy Recipes from ELT and other HAP staff along with volunteer days at the food bank
    - Sponsor of the Empty Bowls fundraiser
- HAP continued to provide monthly sponsorship and volunteer efforts with Cass Social Services and the Noah Project (Homeless)
- HAP partnered with Detroit Health Department (DHD) to host a series of Immunization events for children throughout the City of Detroit.
    - Both HAP and DHD outreach specialists contacted parents or guardians to assist in scheduling well-child visits and review their children's screening and immunization needs. HAP members received rewards for attending the well-child visit
- Enhanced SMS outreach to add new care gap messages including annual wellness visits, dental care reminders, and flu vaccine reminders

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Goals and Objectives

Each year HAP CareSource sets goals and objectives for its Quality Improvement (QI) activities designed to improve the level of care and service provided to its members. Annually, HAP CareSource reviews the QAPI to evaluate the value and effectiveness of activities implemented throughout the year and to determine if goals and objectives are met. Program revisions are dependent on clinical outcomes, effectiveness of interventions, contractual agreements, accreditation standards requirements, budget, and overall satisfaction with meeting goals of the QAPI.

Quality Program Evaluation

The Quality Program was developed to ensure alignment with the HAP Unifying Concept strategies, stakeholder/purchaser and regulatory requirements, and accreditation standards. The program document is enhanced annually and as necessary to capture the increased focus on patient safety and behavioral health initiatives. We will continue to evaluate plan-wide achievement of organizational goals on a quarterly basis. The quarterly review ensures adherence to the organizational vision, goals, strategies, and the opportunity to evaluate effectiveness of the interventions in a timely manner.

The Quality Program annual evaluation provides both qualitative and quantitative evaluations of plan-wide performance. HAP CareSource provides information on the effectiveness of the Quality Program annually to network providers. Evaluations are available on the plan website annually; providers are notified of the availability of program documents.

The Quality Program Work Plan evaluation tool is a quarterly review of the plan's ability to accomplish organizational goals and objectives as well as an evaluation of the accomplishments, limitations, and recommendations for future goals and objectives. The QI Workplan evaluation is shared with MDHHS on an annual basis.

- QI activities and objectives for improving the quality & safety of clinical care, quality of service and members' experience
- Time frame for each activity's completion
- Staff members responsible for each activity
- Monitoring of progress and/or barriers

HAP CareSource's Quality Program encompasses strategies to design programs that are population based and provide for identification of high-risk members with chronic conditions for enrollment into health coaching and case management programs; measure performance outcomes; and support systematic follow-up on the effectiveness of interventions. Additionally, the quality improvement projects address clinical and non-clinical activities and are based on measurable, evidence-based, achievable outcomes that are analyzed annually. The outcomes are reported to the CQMC and Board of Directors.

HEDIS® Performance Outcomes Measures Results

Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA®) to objectively measure, report, and compare quality across health plans. NCQA® develops HEDIS® measures through a committee represented by purchasers, consumers, health plans, health care providers, and policy makers. As state

and federal governments move toward a quality-driven healthcare industry, HEDIS® scores are becoming more important for both health plans and individual providers.

HAP CareSource recognizes the importance of assisting the Medicaid population in obtaining preventive care which improves health outcomes and can prevent diseases. HAP CareSource has utilized the HEDIS® in conjunction with breakdowns in member's demographics and social determinants of health to identify members in need of preventive services, their barriers, and opportunities for improvement to create programs/interventions that aim to encourage Medicaid members to complete those needed preventive services.

The intent of this evaluation is to provide a brief, high-level summary of HAP CareSource's MY 2022 HEDIS® performance compared to its goals and to highlight any improvements made over the past year. The analysis includes information related to three-year trending of measures and compares the final HEDIS® MY 2022 rates against the NCQA® National Benchmarks and Thresholds.

For MY 2022, HAP CareSource achieved the following NCQA® benchmarks:

- 75th NCQA® Percentile:
    - (CHL) Chlamydia Screening
    - (AAP) Adults' Access to Preventive/Ambulatory Health Services: 65+ Years
    - (WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile
    - (WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition Total
    - (WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Physical Activity Total
- 50th NCQA® Percentile:
    - (CBP) Controlling High Blood Pressure
    - (BCS) Breast Cancer Screening
    - (HBD) Hemoglobin A1c Control for Patients with Diabetes: Poor Control
    - (HBD) Hemoglobin A1c Control for Patients with Diabetes: Adequate Control)
    - (EED) Eye Exam for Patients with Diabetes
    - (KED) Kidney Health Evaluation for Patients with Diabetes: 18-64 Years
    - (KED) Kidney Health Evaluation for Patients with Diabetes: 65-74 Years
    - (KED) Kidney Health Evaluation for Patients with Diabetes: 75-85 Years
    - (KED) Kidney Health Evaluation for Patients with Diabetes: Total

The following analyzes HEDIS® measures for member access, prevention, child prevention and immunizations and diabetes care. In addition, a summary of HAP CareSource's efforts to improve HEDIS® measures is included.

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Children and Adolescent Preventive Care

EPSDT

Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) services to Medicaid eligible beneficiaries younger than 21 years of age; however, beneficiary participation is voluntary. The intent of EPSDT is to correct or ameliorate defects in physical and mental illnesses and conditions discovered by screening services.

Providers are responsible for providing Well-Child Visits, including immunizations and developmental screening, at specified intervals as defined in the periodicity schedule by the American Academy of Pediatrics (AAP). To encourage providers to perform member outreach and provide age-appropriate services, HAP CareSource offers Primary Care Physicians and members EPSDT financial incentives.

Well-Child Visits

Well-Child Visits provide an opportunity for the Primary Care Physician to obtain an initial history or interval history, promote healthy lifestyle choices, monitor children's physical and behavioral health, and provide age-appropriate anticipatory guidance and education. It is during these Well-Child Visits that potential health problems may be detected and prevented or treated in the early stages, thereby reducing the negative effects of these problems. Components of a Well-Child Visit include a physical examination, counseling in nutrition and physical activity, various immunizations, and various screenings such as sensory, developmental, behavioral, and lead screenings.

HAP CareSource focused on Well-Child Visits in MY 2022 for several important reasons including that the state of Michigan recognizes a decrease in immunizations, lead screenings, and other preventive screenings. Therefore, it is essential that HAP CareSource monitors progress for these measures through annual HEDIS® and monthly gaps in care reports through the software vendor. The following are results for several childhood preventive health measures.

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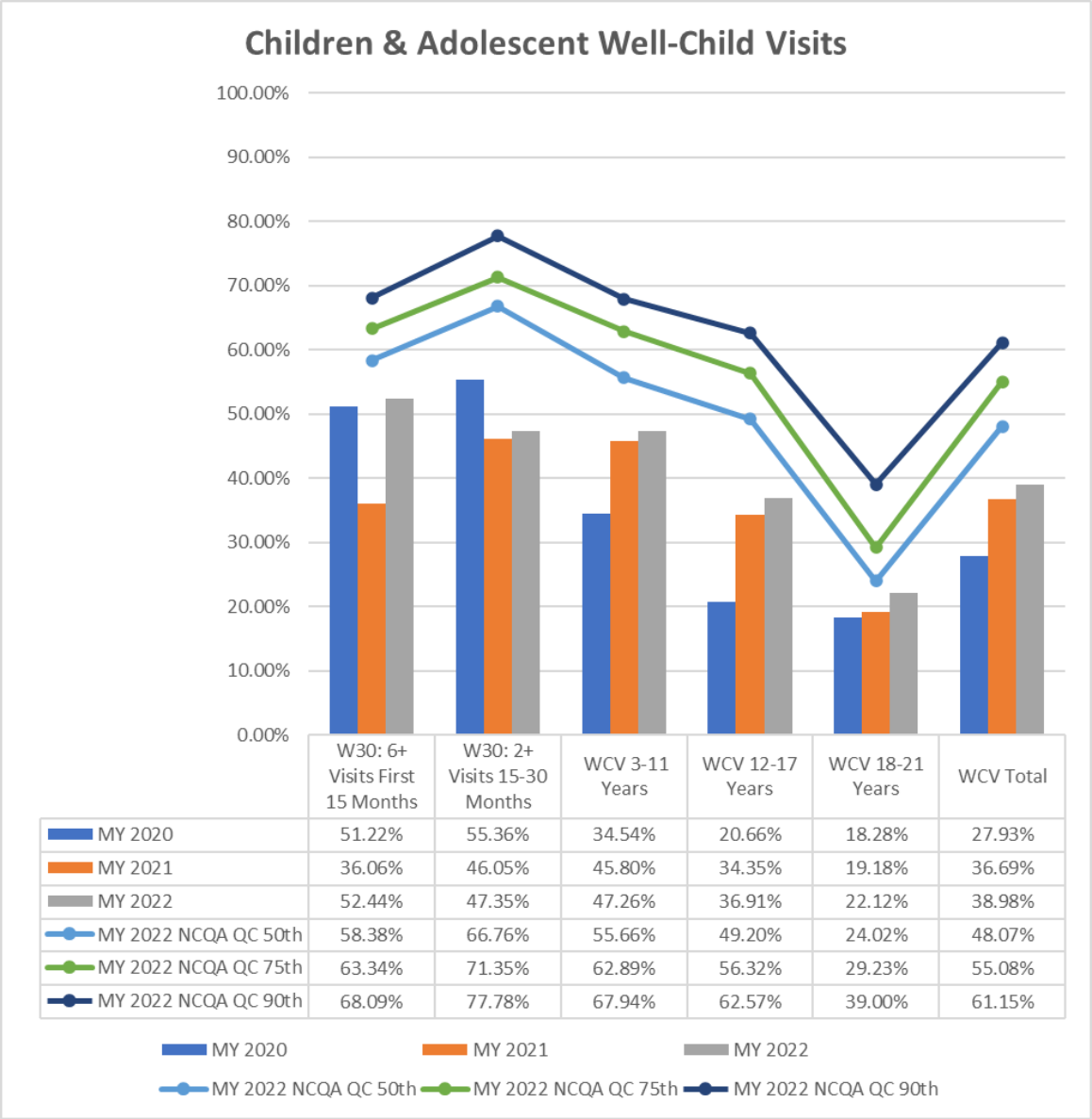
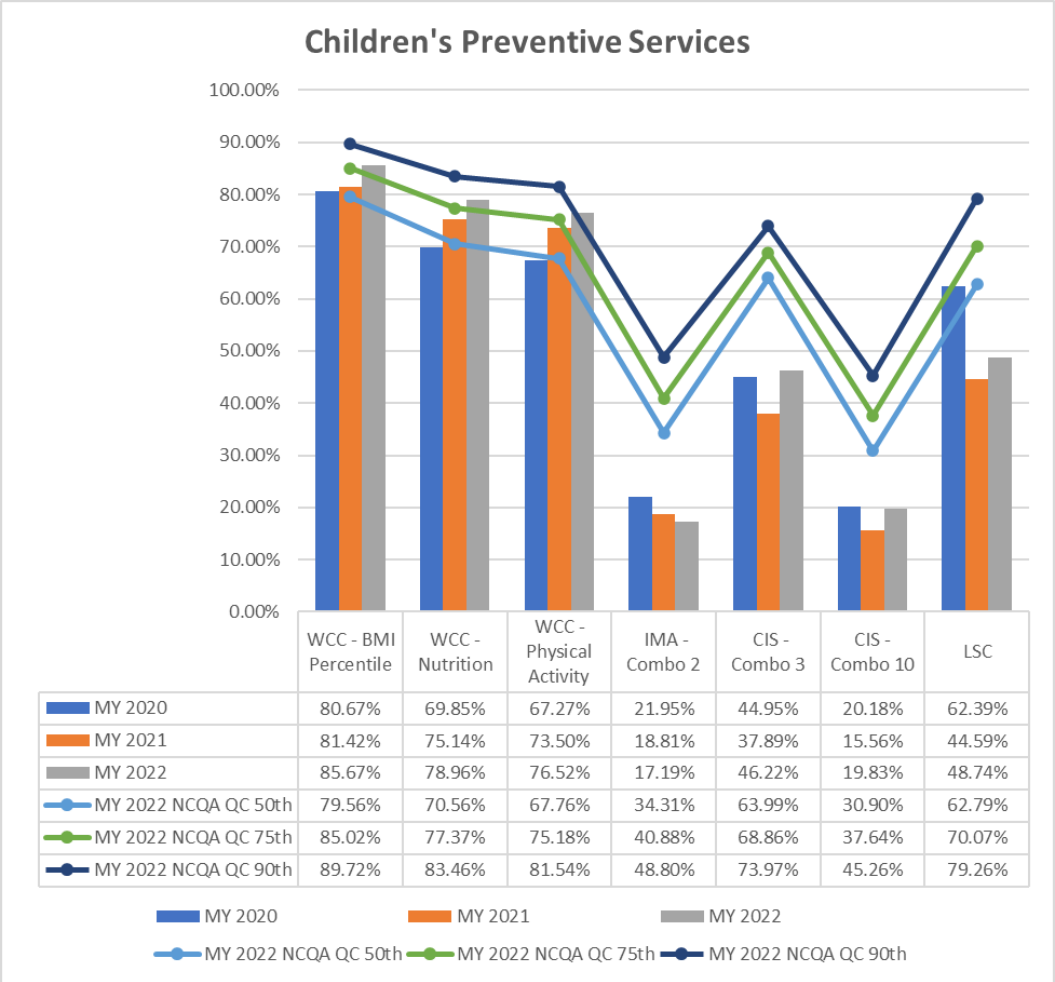
Graph 1



	W30: 6+ Visits First 15 Months	W30: 2+ Visits 15-30 Months	WCV 3-11 Years	WCV 12-17 Years	WCV 18-21 Years	WCV Total
MY 2020	51.22%	55.36%	34.54%	20.66%	18.28%	27.93%
MY 2021	36.06%	46.05%	45.80%	34.35%	19.18%	36.69%
MY 2022	52.44%	47.35%	47.26%	36.91%	22.12%	38.98%
MY 2022 NCQA QC 50th	58.38%	66.76%	55.66%	49.20%	24.02%	48.07%
MY 2022 NCQA QC 75th	63.34%	71.35%	62.89%	56.32%	29.23%	55.08%
MY 2022 NCQA QC 90th	68.09%	77.78%	67.94%	62.57%	39.00%	61.15%

Graph 2



	WCC - BMI Percentile	WCC - Nutrition	WCC - Physical Activity	IMA - Combo 2	CIS - Combo 3	CIS - Combo 10	LSC
MY 2020	80.67%	69.85%	67.27%	21.95%	44.95%	20.18%	62.39%
MY 2021	81.42%	75.14%	73.50%	18.81%	37.89%	15.56%	44.59%
MY 2022	85.67%	78.96%	76.52%	17.19%	46.22%	19.83%	48.74%
MY 2022 NCQA QC 50th	79.56%	70.56%	67.76%	34.31%	63.99%	30.90%	62.79%
MY 2022 NCQA QC 75th	85.02%	77.37%	75.18%	40.88%	68.86%	37.64%	70.07%
MY 2022 NCQA QC 90th	89.72%	83.46%	81.54%	48.80%	73.97%	45.26%	79.26%

Qualitative Analysis

HAP CareSource had a goal of achieving the 50th percentile for Well-Child Visits and other childhood preventive health measures for MY 2022. HAP CareSource exceeded the goal for the WCC measures by meeting the 75th percentile for BMI Percentile, Counseling for Nutrition, and Counseling for Physical Activity. Unfortunately, HAP CareSource did not reach the goal for some of the other measures. However, some measures continued to increase and have statistically significant improvement from the previous year. HAP CareSource used the Chi-Square Calculation to determine if these measures had statistically significant improvement (where if the p-value <0.05 indicates statistically significant improvement). For example, CIS: Combo 3 increased by 8.33% and had a p-value = 0.00989 indicating statistically significant improvement. Lead Screening in Children (LSC) did not have statistically significant improvement, but the denominator size continued to grow. The LSC denominator went from 388 members in MY 2021 to 597 members in MY 2022 and the denominator size grew by 53.87% (209 members).

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While HAP CareSource did not reach its goal of the 50th percentile for the WCV measures or the W30 measures, these measures did have statistically significant improvement from the previous year. For instance, W30: 6+ Visits in First 15 Months increased by 16.38% and had a p-value = 0.00013 indicating statistically significant improvement. While some measures did not have statistically significant improvement, the denominator size continued to grow. For example, WCV: Total went from 5,276 members in MY 2021 to 6,439 members in MY 2022 and the denominator size grew by 22.04% (1,163 members).

In October 2022, HAP CareSource hired two (2) Health Outreach Specialists whose primary focus was to telephonically outreach members due for well-child visits. During these outreaches, the Health Outreach Specialists reminded members of the preventive care that were due in addition to the well-child visit such as lead screenings and immunizations and would provide education around these services explaining the importance of them. Additionally, the Health Outreach Specialists would identify and address social determinants of health barriers and assist in scheduling doctor appointments and transportation (as needed).

On top of the targeted outreach, HAP CareSource revised its Member Rewards Program in 2022, with the goal of making it less burdensome on internal staff, members, and providers and to increase member engagement with preventive care. As a result, HAP CareSource made the Rewards Program automated, meaning that when a claim is processed at HAP CareSource for a reward eligible service, that reward would be automatically mailed to the member. This eliminates the need of the member sending in a form to notify that a reward eligible service was completed so that the reward would be triggered manually. Additionally, HAP CareSource made changes to how the W30 visits would be rewarded. Historically, HAP CareSource provided rewards for each visit needed to make the member compliant for W30: 6+ Well-Child Visits within the first 15 Months and W30: 2+ Well-Child Visits between 15 and 30 Months. In 2022, HAP CareSource required that all 6 Well-Child Visits be completed by the members' 15th month birthday to be eligible for the reward. HAP excluded the W30: 2+ Well-Child Visits between 15 and 30 Months from the Program in 2022. The goal was to reward the members for completing all required visits rather than individual visits. HAP CareSource did include the WCV in the Member Rewards Program in 2022 but excluded the W30: 2+ Well-child Visits Between 15 and 30 Months.

Barriers

- Preventive services are not being completed during the Well-Child Visits such as immunizations and lead screenings.
- Members are not willing to schedule visits in advance due to their constantly changing schedules.
- Many providers are referring members to walk-in clinics for lead screenings due to not having tests on site.
- HAP CareSource needs to engage with Provider Groups and FQHCs in Child and Adolescent preventive care improvement efforts.
- Inaccurate member communication information including phone number or email address.
- Unable to schedule appointments within the necessary timeframe.
- Additional barriers include the social determinants of health issues including - housing status, food security, income, type of employment, and education.

Opportunities for Improvement

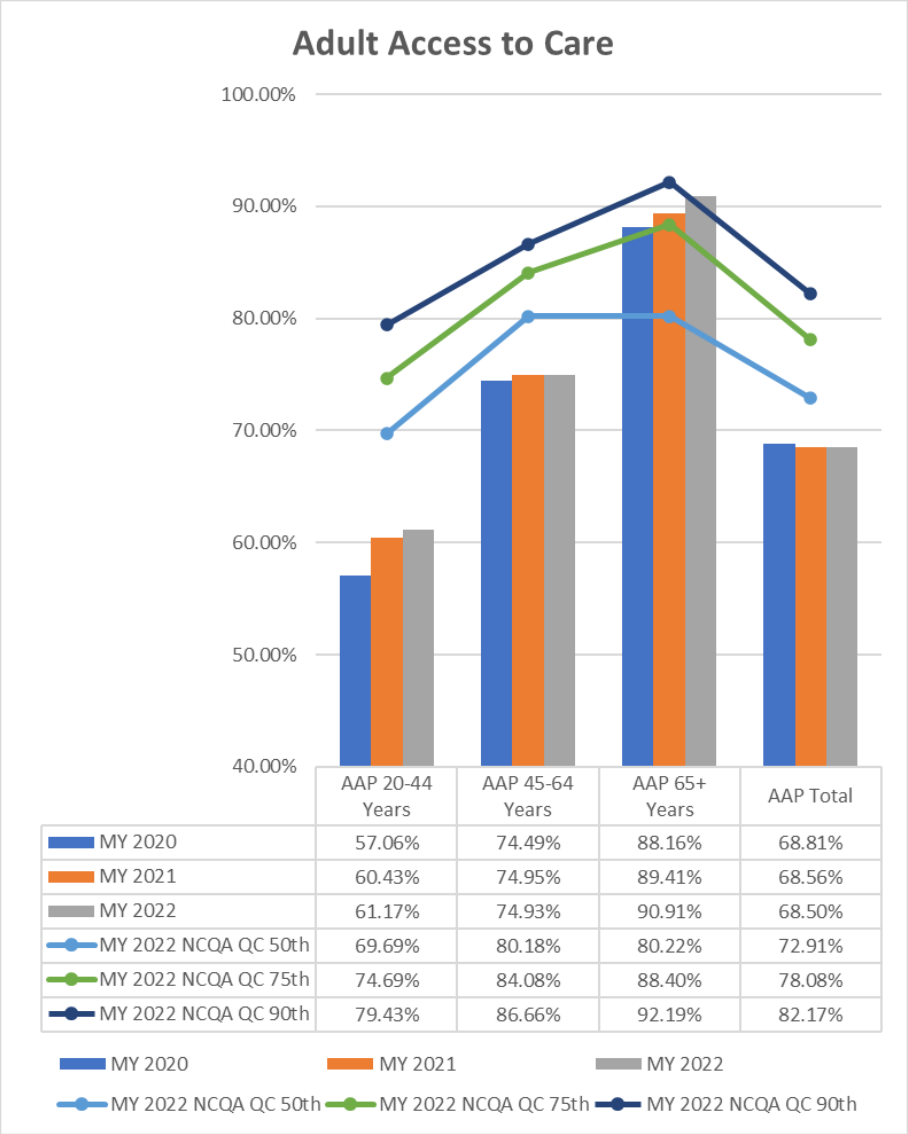
HAP CareSource will revisit implementation of previous initiatives and has implemented new strategies to address the above barriers, including:

- Conduct focused member telephonic outreach and text messaging including educational materials for members to inform them of the importance of preventive screenings and to remind them of incentives and transportation opportunities.
- Revise the Member Rewards Program to reward the behavior of going to the office for the Well-Child Visit instead of rewarding the completion of multiple visits. Expect this to also increase the chance that preventive screenings such as immunizations are completed in a timely manner.
- Continue to identify racial and ethnic disparities through data analysis and focus efforts (programs, initiatives) to address the disparities.
- Provide gaps in care information to providers to assist them in performing outreach to their members and implementing member gaps in care via the provider portal.
- Develop monthly HEDIS reports which will show the FQHCs their HEDIS rates for select measures and will include member level detail so the FQHCs know who has a gap in care.
- Continue to plan and develop child focused clinic events (which can provide COVID-19 vaccinations and lead screenings).
- Continue to employ Alternative Payment Models and Value Based Payments.
- Closely partner with targeted provider groups and Federally Qualified Health Centers (FQHCs) to improve their compliance rates.

Adult Access to Care

It is important for adults ages 20 years and older to see their provider at least once a year. These annual visits allow the members to have their vitals checked, discuss topics and concerns such as preventive care needs (examples include cervical cancer screenings) and to manage those chronic conditions. HAP CareSource has been focused on improving performance for Adults' Access to Preventive/Ambulatory Services (AAP) as members get more comfortable obtaining preventive care services after the pandemic. Additionally, AAP is a measure that impacts several quality programs such as Medicaid Auto-Assignment, Consumer Guide, and Bonus Template.

Graph 3



	AAP 20-44 Years	AAP 45-64 Years	AAP 65+ Years	AAP Total
MY 2020	57.06%	74.49%	88.16%	68.81%
MY 2021	60.43%	74.95%	89.41%	68.56%
MY 2022	61.17%	74.93%	90.91%	68.50%
MY 2022 NCQA QC 50th	69.69%	80.18%	80.22%	72.91%
MY 2022 NCQA QC 75th	74.69%	84.08%	88.40%	78.08%
MY 2022 NCQA QC 90th	79.43%	86.66%	92.19%	82.17%

Qualitative Analysis

HAP CareSource had a goal of the 50th percentile for AAP: 20-44 Years, 45-64 Years, and the Total sub-measures in MY 2021. Unfortunately, HAP CareSource has struggled to meet this goal for some of these sub-measures. Although HAP CareSource didn't meet the goal for these measures and did not see statistically significant improvement, the denominator size continued to grow, and the population grew. For example, AAP: 20-44 Years denominator size grew by 35.62% (3,602 members) from MY 2021 to MY 2022. In addition, AAP: 20-44 Years saw an improvement in the rate from MY 2021 to MY 2022.

HAP CareSource had a goal of the 75th percentile for MY 2022 for AAP: 65+ Years since this measure has historically hit the 50th percentile. HAP CareSource exceeded this goal in MY 2022 by 64 numerator hits with a rate of 90.91% and again saw improvement in the rate from the previous year.

Several interventions were implemented in MY 2022 that were aimed at improving Adults' Access to Care. HAP CareSource revamped its member rewards program where members were eligible to receive a $50 gift voucher for seeing their provider. In addition, HAP CareSource enhanced the member rewards program to make it less burdensome, moving it from a form-based program to a claim-based program. HAP CareSource reviewed and updated its Customer Service Resource (CSR) Tool. The CSR Tool is an internally developed tool that member-facing staff can use to help provide reminders to members that they are due for preventive services such as Adult Access to Care.

Barriers

- Redeterminations were paused in MY 2022, allowing everyone how had Medicaid when the emergency went into effect to keep their Medicaid coverage. Many of these members may have moved out of the service area or have moved to an employer-based health insurance causing issues with getting members in for care and in getting the claims for care that the member may have received (as those claims may have gone to the employer-based insurance instead of Medicaid).
- Additional factors affecting preventive care and access to care rates include missing, incorrect, or incomplete contact information that results in unsuccessful member contact and members having transportation issues.
- Additional barriers include racial and ethnic disparities, and social determinants of health, housing and food insecurity, income, type of employment, poverty, and education.
- Lack of targeted gaps in care outreach to this population.

Opportunities for Improvement

HAP CareSource will revisit implementation of previous initiatives and has implemented new strategies to address the above barriers, including:

- Continue incentivizing members for annual primary care provider visits.
- Develop high touch gaps in care outreach campaign that includes texting, telephonic outreach, and mail.
- Continue to identify racial and ethnic disparities through data analysis and focus efforts (programs, initiatives) to address the disparities.
- Provide gaps in care information to providers to assist them in performing outreach to their members and implementing member care gaps via the provider portal.
- Develop close partnerships with high-volume provider groups and FQHCs for improvement activities.
- Continue to employ Alternative Payment Models and Value Based Payments.
- Continue to identify data sources that can be implemented or enhanced.

<u>Women's Preventive Care</u>

Women's Preventive Care includes preventive screenings such as Cervical Cancer Screening (CCS), Breast Cancer Screening (BCS), Chlamydia Testing in Women (CHL), as well as Timeliness in Prenatal Care and Postpartum Care Visits. In 2022, HAP CareSource focused on improving rates for Women's Preventive Care through internal interventions and partnerships with provider offices. It is important for women to complete these services when recommended so that diseases and illnesses can be detected early and therefore lead to better outcomes.

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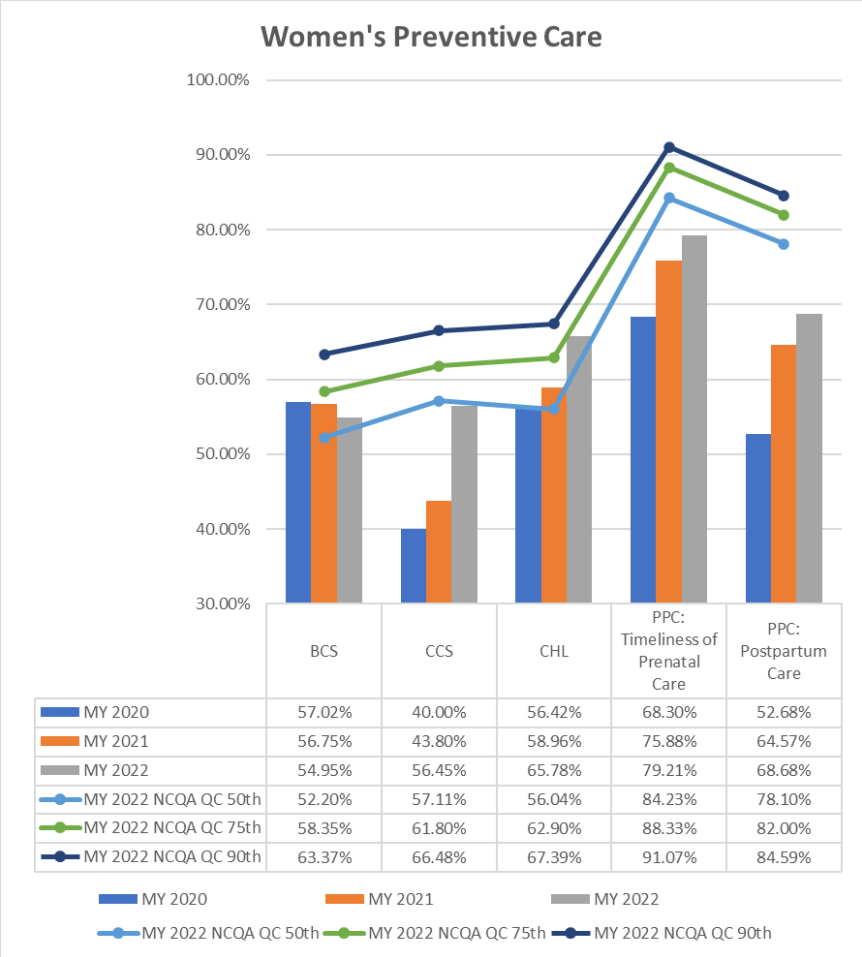
Graph 4



	BCS	CCS	CHL	PPC: Timeliness of Prenatal Care	PPC: Postpartum Care
MY 2020	57.02%	40.00%	56.42%	68.30%	52.68%
MY 2021	56.75%	43.80%	58.96%	75.88%	64.57%
MY 2022	54.95%	56.45%	65.78%	79.21%	68.68%
MY 2022 NCQA QC 50th	52.20%	57.11%	56.04%	84.23%	78.10%
MY 2022 NCQA QC 75th	58.35%	61.80%	62.90%	88.33%	82.00%
MY 2022 NCQA QC 90th	63.37%	66.48%	67.39%	91.07%	84.59%

Qualitative Analysis

HAP CareSource had a goal of the 50th percentile for the Prenatal and Postpartum Care (PPC) measures and Cervical Cancer Screening (CCS) measure. CCS was only five (5) numerator hits away from the 50th NCQA® Quality Compass (QC) benchmark with a rate of 56.45%. CCS had a 12.65 difference in rates and had p-value = 0.00029 indicating statistically significant improvement.

In addition, there are other areas of improvement in performance from MY 2021 to MY 2022. Although Timeliness of Prenatal Care (PPC) and Postpartum Care (PPC) did not reach the goal of the 50th percentile, HAP CareSource saw improvement in the rates. For example, PPC: Postpartum Care had 11.89% difference in rates and had statistically significant improvement (p-value = 0.00361). In addition, HAP CareSource increased the prenatal member reward from $50 to $75 in 2022. Due to the NCQA HEDIS Technical Specifications requiring the Prenatal Visit to occur within the first trimester or within 42 days of enrollment with the health plan, this service was kept as a manual reward. This was to allow for an immediate reward for completing the service rather than waiting to issue the reward until the member delivered, promoting behavioral economics.

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BCS had a decline in performance from MY 2021 to MY 2022 with a decrease of 1.80 percentage points. Although BCS had a decline in performance, BCS exceeded the 50th percentile by 66 numerator hits with a rate of 54.95%. This decline is partially contributed to the Region 10 members that were acquired through the Trusted acquisition in 2019 finally falling into the BCS denominator. The NCQA HEDIS Technical Specifications require that members are continuously enrolled with the health plan for at least 3 years. The Trusted Region 10 members had an effective date of 1/1/2020, allowing them to fall into the denominator in 2022. The BCS denominator went from 1,103 members in MY 2021 to 1,645 members in MY 2022 and denominator size grew by 49.14% (542 members).

HAP CareSource partnered with Henry Ford Health to host clinic days where women's preventive health screening could be completed such as BCS, CHL, and CCS screening. HAP CareSource conducted outreach for members who were due for any of these screenings to inform them of the clinic days. HAP CareSource received a list of members who attended and received the claims list of services included in the member rewards program so that members could receive their reward.

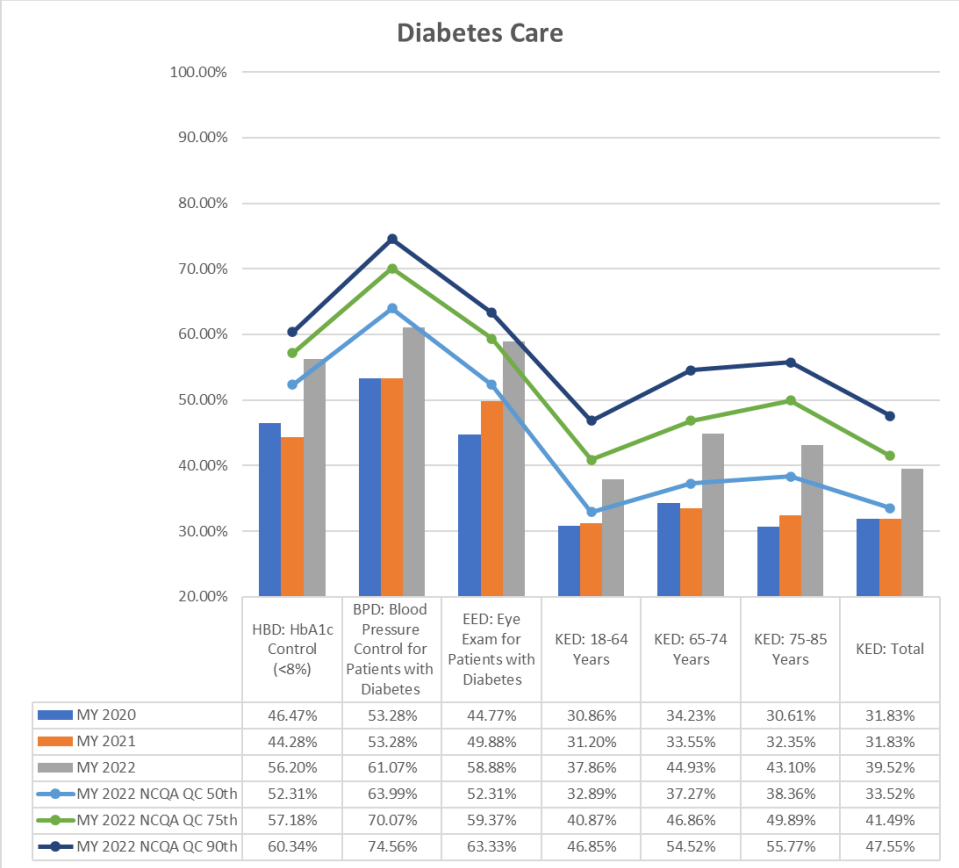
Barriers

- Redeterminations were paused in MY 2022, allowing everyone how had Medicaid when the emergency went into effect to keep their Medicaid coverage. Many of these members may have moved out of the service area or have moved to an employer-based health insurance causing issues with getting members in for care and in getting the claims for care that the member may have received (as those claims may have gone to the employer-based insurance instead of Medicaid).
- Missing, incorrect, or incomplete contact information that results in unsuccessful member contact and members having transportation issues.
- Social determinants of health barriers such as housing and food insecurity, income, type of employment, poverty, and education prevent members from seeking needed care.

Opportunities for Improvement

- Continue to implement women's events focused on providing needed screenings while growing partnerships with providers which can assist in closing gaps.
- Develop a high-touch gaps in care outreach program that includes texting, telephonic, email, and mail to remind members of the gaps they are due for and services available to them.
- Continue to provide providers with performance metrics around these measures so they can monitor their gap closure progress and improve performance.
- Partner with provider groups and FQHCs in closing gaps in care while delivering monthly member detail reports.
- Continue to identify data sources that can be implemented or enhanced.

Graph 5



	HBD: HbA1c Control (<8%)	BPD: Blood Pressure Control for Patients with Diabetes	EED: Eye Exam for Patients with Diabetes	KED: 18-64 Years	KED: 65-74 Years	KED: 75-85 Years	KED: Total
MY 2020	46.47%	53.28%	44.77%	30.86%	34.23%	30.61%	31.83%
MY 2021	44.28%	53.28%	49.88%	31.20%	33.55%	32.35%	31.83%
MY 2022	56.20%	61.07%	58.88%	37.86%	44.93%	43.10%	39.52%
MY 2022 NCQA QC 50th	52.31%	63.99%	52.31%	32.89%	37.27%	38.36%	33.52%
MY 2022 NCQA QC 75th	57.18%	70.07%	59.37%	40.87%	46.86%	49.89%	41.49%
MY 2022 NCQA QC 90th	60.34%	74.56%	63.33%	46.85%	54.52%	55.77%	47.55%

Qualitative Analysis

HAP CareSource had a goal of the 50th percentile for diabetes care measures. HAP CareSource met the goal of the 50th percentile for HBD: HbA1C Poor Control (which is not displayed in the graph since this measure is reported as an inverse measure) and HBD: HbA1C Control. In addition, HAP CareSource met the 75th percentile for EED: Eye Exam for Patients with Diabetes. While EED exceeded the 75th percentile, it also had 9.00% difference in rates and statistically significant improvement (p-value = 0.00957). Although BPD did not achieve the goal of the 50th percentile, BPD had 7.79% difference in rates and had statistically significant improvement (p-value = 0.02409).

Interventions were implemented in MY 2022 that were aimed at making diabetes care more accessible to diabetic Medicaid members. In MY 2022, HAP CareSource continued its partnership with Matrix Home Health. Matrix Home Health conducts telephonic outreach to members who need a diabetic retinal eye exam to schedule an in-home diabetic retinal eye exam appointment. Results of the exams are shared with the members' primary care provider. In addition, Matrix would send members who were due for A1c testing an in-home testing kit that could be mailed back for analysis. Additionally, HAP CareSource partnered with Home Access on a kit campaign, where members who were due for a HbA1c Test or had a poor controlled HbA1c rate were mailed a home HbA1c testing kit. These kits were easy to use and

were free to the members. Additionally, the member's results through these programs were also shared with the member's doctor.

HAP CareSource has also been focused on reducing data gaps by evaluating existing data sources and identifying potential new data sources. Through this effort, HAP CareSource learned it was not getting all the lab results from Henry Ford Health. Henry Ford Health sends monthly lab files but has historically only sent it for members that are assigned to Henry Ford Health. HAP CareSource was able to enhance this file so that it includes all HAP CareSource members that had a lab completed at Henry Ford Health. This had a large impact on HAP CareSource HbA1c Control and Poor Control rates as well as BPD. For example, the enhancement improved HAP CareSource HbA1c Control rate by about 7 percentage points. Additionally, HAP CareSource implemented the MiHIN QMI file for the first time in MY 2022 which also had a positive impact on the HEDIS rates.

Barriers

- Redeterminations were paused in MY 2022, allowing everyone how had Medicaid when the emergency went into effect to keep their Medicaid coverage. Many of these members may have moved out of the service area or have moved to an employer-based health insurance causing issues with getting members in for care and in getting the claims for care that the member may have received (as those claims may have gone to the employer-based insurance instead of Medicaid).
- Additional factors affecting the comprehensive diabetes care rates include member transportation issues and missing, incorrect, or incomplete contact information that results in unsuccessful member contact.
- Additional barriers include racial and ethnic disparities, and social determinants of health – housing and food insecurity, income, type of employment, poverty, and education.

Opportunities for Improvement

HAP CareSource will revisit implementation of previous initiatives and has implemented new strategies to address the above barriers, including:

- Continue to reward members to encourage members to complete the necessary diabetes care.
- Continue a high-touch gaps in care outreach program that includes texting, telephonic, email, and mail to remind members of the gaps they are due for and services available to them.
- Continue to identify racial and ethnic disparities through data analysis and focus efforts (programs, initiatives) to address the disparities and identify locations for targeted interventions.
- Continue to identify data sources that can be implemented or enhanced.

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HAP CareSource HEDIS Table – Measurement Years 2020 – 2022

Measure/Data Element	HAP CareSource's Rates			NCQA® Quality Compass 2022		
	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	50th Percentile	75th Percentile	90th Percentile
Child and Adolescent Prevention						
Child and Adolescent Well-Care Visits (WCV: (3-11)	34.54%	45.80%	37.26%	55.66%	62.89%	67.94%
Child and Adolescent Well-Care Visits (WCV): 12-17 Years	20.66%	34.35%	36.91%	49.20%	56.32%	62.57%
Child and Adolescent Well-Care Visits (WCV): 18-21 Years	18.28%	19.18%	22.12%	24.02%	29.23%	39.00%
Child and Adolescent Well-Care Visits (WCV): Total	27.93%	36.69%	38.98%	48.07%	55.08%	61.15%
Well-Child Visits in the First 30 Months of Life (W30): First 15 Months	51.22%	36.06%	52.44%	58.38%	63.34%	68.09%
Well-Child Visits in the First 30 Months of Life (W30): 15 Months-30 Months	55.36%	46.05%	47.35%	66.76%	71.35%	77.78%
Lead Screening in Children (LSC)	62.39%	44.59%	48.74%	62.79%	70.07%	79.26%
Childhood Immunization Status (CIS): Combination #3	44.95%	37.89%	46.22%	63.99%	68.86%	73.97%
Childhood Immunization Status (CIS): Combination #10	20.18%	15.46%	19.83%	30.90%	35.04%	37.64%
Immunizations of Adolescents (IMA): Combination #2	21.95%	18.81%	17.19%	34.31%	40.88%	48.80%
WCC: BMI Percentile	80.67%	81.42%	**85.67%**	79.56%	85.02%	89.72%
WCC: Counseling for Nutrition	69.85%	75.14%	**78.96%**	70.56%	77.37%	83.46%
WCC: Counseling for Physical Activity	67.27%	73.50%	**76.52%**	67.76%	75.18%	81.54%
Adult Prevention/Wellness						
Adults' Access to Preventive/Ambulatory Health Services (AAP): 20-44 Years	57.06%	60.43%	61.17%	69.69%	74.69%	79.43%
Adults' Access to Preventive/Ambulatory Health Services (AAP): 45-64 Years	74.49%	74.95%	74.93%	80.18%	84.08%	86.66%

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Measure/Data Element	HAP CareSource's Rates			NCQA® Quality Compass 2022		
	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	50th Percentile	75th Percentile	90th Percentile
Adults' Access to Preventive/Ambulatory Health Services (AAP): 65+ Years	88.16%	89.41%	**90.91%**	80.22%	88.40%	92.19%
Adults' Access to Preventive/Ambulatory Health Services (AAP): Total	68.81%	68.56%	68.50%	72.91%	78.08%	82.17%
Women's Health						
Prenatal and Postpartum Care - Timeliness of Prenatal Care	68.30%	75.88%	79.21%	84.23%	88.33%	91.07%
Prenatal and Postpartum Care - Postpartum Care	52.68%	64.57%	68.68%	78.10%	82.00%	84.59%
Breast Cancer Screening (BCS)	57.02%	56.75%	**54.95%**	52.20%	58.35%	63.37%
Cervical Cancer Screening (CCS)	40.00%	43.80%	56.45%	57.11%	61.80%	66.48%
Chlamydia Screening in Women (CHL): Total	56.42%	58.96%	**65.78%**	56.04%	62.90%	67.39%
Diabetes Care						
Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control	46.96%	50.12%	35.77%	37.96%	33.45%	29.44%
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	46.47%	44.28%	56.20%	52.31%	57.18%	60.34%
Eye Exam for Patients with Diabetes (EED)	44.77%	49.88%	58.88%	52.31%	59.37%	65.69%
Blood Pressure Control for Patients With Diabetes (<140/90) (BPD)	53.28%	53.28%	61.07%	63.99%	70.07%	74.56%
Kidney Health Evaluation for Patients with Diabetes: 18-64 Years	30.86%	31.20%	37.86%	32.89%	40.87%	46.85%
Kidney Health Evaluation for Patients with Diabetes: 65-74 Years	34.23%	33.55%	44.93%	37.27%	48.68%	54.52%
Kidney Health Evaluation for Patients with Diabetes: 75-85 Years	30.61%	32.35%	43.10%	38.36%	49.89%	55.77%
Kidney Health Evaluation for Patients with Diabetes: Total	31.83%	31.83%	39.52%	33.52%	41.49%	47.55%
Pharmacy						
Controlling High Blood Pressure (CBP)	52.55%	57.32%	62.53%	61.31%	67.27%	72.22%

CQMC: 2/20/2024

Measure/Data Element	HAP CareSource's Rates			NCQA® Quality Compass 2022		
	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	50th Percentile	75th Percentile	90th Percentile
Asthma Medication Ratio (AMR): Total	46.27%	48.30%	52.03%	65.61%	70.82%	75.92%

Improvement Activities

HAP CareSource will revisit implementation of previous initiatives and has implemented new strategies to address the above barriers, including:

- Continue incentivizing members and providers for annual Primary Care Provider Visits and women's preventive screenings.
- Continue focused member telephonic outreach, text messaging and email reminders.
- Identify racial and ethnic disparity through data analysis and focus efforts (programs, initiatives) to address the disparities.
- Continue Women's Events focused on providing needed screenings.
- Providing gaps in care information to providers to assist them in performing outreach to their members and implementing member gaps in care via the provider portal
- Continue to employ Alternative Payment Models and Value Based Payments.
- Targeted outreach for well-child visits and providing reminders on additional preventive services that may be needed.
- Engage with high-volume Provider Groups and FQHC's with the goal of partnering on improvement initiatives.
- Improve and enhance data sources that will allow HAP CareSource to have more complete data.

Maternity Management Program

The HAP CareSource Maternity Management program powered by ProgenyHealth ensures members have a health pregnancy by:

- Connecting members with an OB or OB/GYN
- Providing reminders for prenatal and postpartum visits, and assisting with scheduling if needed
- Conducting maternity-specific assessments in order to ensure members are receiving the care they need
- Educating on benefits available while pregnant, including dental services
- Connecting members to nurses or behavioral health services if needed
- Referring members to a Maternal Infant Health Program (MIHP). MIHPs offer in-home visits by qualified nurses or social workers to provide education and support
- Checking in with members after delivery to make sure everyone is doing well
- Ongoing education, and support through the Ovia Health™ mobile application

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Maternal Infant Health Program (MIHP)

The Maternal Infant Health Program (MIHP) is a home-visiting program for Medicaid-eligible women and infants to promote healthy pregnancies, positive birth outcomes, identify risk, deliver interventions, measure outcomes, and promote healthy infant growth and development. Health plans are required to have a signed care coordination agreement and contract with each MIHP Provider in their service areas. The purpose of the care coordination agreement and contract is to define the responsibilities and relationship between the MIHP Provider and HAP CareSource.

HAP CareSource continues to refer all pregnant members and infants to MIHP. HAP continued contracting activities in 2023 with all MIHP providers operating in the service area. MIHP helps pregnant members and infants get the proper food, support, and transportation for all health services. It also helps emphasize the importance of getting prenatal care, childcare, and shots when they are scheduled. MIHP services include prenatal teaching, childbirth education classes, nutritional support and education, newborn baby assessments, referrals to community resources and help in finding baby cribs, car seats, and clothing, help with transportation to pregnancy related appointments, and support to stop smoking.

MIHP Interventions

Date	Frequency	Intervention
Ongoing	As needed	Continued oversight of contracts and care coordination agreements with MIHP Provider's in HAP service area
Ongoing	Monthly	Identify Pregnant women and infants; send referral to MIHP in member's county
Ongoing	As needed	Contact MIHP Provider regarding status of care coordination agreement
Ongoing	As needed	Follow up with MIHP Providers regarding status of referrals
Ongoing	Monthly	Use the pregnancy indicator and claims reports to identify members for the Maternal Infant Health Program on a monthly basis

On a monthly basis, HAP utilizes the pregnancy indicator to identify members for the Maternal Infant Health Program. Referrals are made by email, phone, or fax. Referrals made by email are in Microsoft excel format and are secured through password protection. HAP collaborates and maintains care coordination agreements with MIHP providers in HAP service areas. The MIHP Provider is responsible for sending reports of HAP members enrolled in MIHP services. HAP maintains registries of those members enrolled in MIHP services. HAP understands the importance of educating members about MIHP services and will continue to provide referrals for MIHP to its Medicaid pregnant women and infant members. Data related to HEDIS 2023 (Measurement Year 2022) is below.

- 22/197(11.16%) members enrolled in the ProgenyHealth case management program.
- Of those enrolled, 16/22 (72.72% received timely prenatal care
- 121/197 (61.42%) received member incentive mailing

- 84/121(69.42%) had timely prenatal care and earned the prenatal incentive.
- 76/197 (38.57%) received a text message incentive reminder. Of those that received a text message, 64/76 (84.21%) had timely prenatal care and earned the incentive.
- 34/197 (17.25%) members enrolled in the MIHP program. Of those enrolled, 26/34 (76.47%), received timely prenatal care

Low Birth Weight (LBW)

In 2023, HAP CareSource in partnership with ProgenyHealth implemented the following to improve outcomes for LBW measure:

- Increasing member engagement through marketing to HAP CareSource members and HAP CareSource providers to ensure awareness of the Maternity Care Management Program resulting in early prenatal care to decrease pregnancy risks and promote healthy birthweight.
- Early identification of Social Determinants of Health impacting a healthy pregnancy and associated interventions to overcome the following: transportation barriers; food insecurity; mental health needs; medication/supply expenses; tobacco, alcohol or substance use; cultural considerations; language barriers, etc.
- Educating members on and connecting with programs like MIHP, Women, Infants and Children (WIC) nutrition program, smoking cessation, drug and alcohol treatment programs, Livongo (for management of diabetes), etc.
- Early and frequent assessment of Behavioral Health needs and referral to services as appropriate.
- Informing members of the incentive program for maternity services; A member is eligible to receive a $50 gift card for timely prenatal care. The incentive is based on claims and reward is paid on a weekly basis.
- A provider toolkit is available on the website that includes resources for providers to utilize with members. This includes mental health, MIHP, tobacco cessation, health equity training, MC3 perinatal program.

Lessons learned include the below which will impact the FY24 improvement plans:

- Increasing member outreach through multiple channels (telephonic, print, mail, text, app) is key to ensuring member engagement in programs.
- Early identification of Social Determinants of Health (SDoH) impacting a healthy pregnancy such as transportation barriers, food insecurity, mental health needs, tobacco cessation, substance abuse disorders, language barriers will assist in care plan development and eliminating the barriers can help member focus on medical care needs while building trust.
- Ongoing assessment of behavioral health needs is needed.
- Continuation of incentive programs to encourage and engage members to obtain prenatal care.

HAP CareSource continued to implement collaborative interventions with the Region 6 and Region 10 health plans. Monthly workgroup meetings with plans were established to review action plans and discuss ongoing low birth weight improvement strategies. A high-level summary of initiatives is below:

- MC3 Promotion to OB/Gyn Offices

- Partnership with Black Mother Breastfeeding Clubs
- Continue collaboration efforts with MIHPs
- The health plans worked together to develop and distribute consistent member messaging through a social media campaign for the Hear Her Campaign during Black Maternal Health week in April 2023
- Ongoing collaboration with Miracle Project in Region 6

Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ+) Care Quality Improvement Project
The purpose of the LGBTQ+ Care Quality Improvement project is to gain further understanding of the clinical and care management landscape in terms of care coordination and provider competency to address health disparities particular to the LGBTQ+ population. In FY23, HAP CareSource submitted the MDHHS template to describe plan projects and activities that address the needs of LGBTQ+ members. HAP will continue to identify specific quality improvement metrics and activities to continually improve care for LGBTQ+ population. Below is a summary of focus areas for the project:

- Non-Discrimination Policies
- Increasing access to Gender-Affirming Services
    - Gender affirming training
- Improving screening, prescribing, and utilization rates for Pre-Exposure Prophylaxis (PrEP)
- Sexual Health Care Management

Performance Improvement Projects
HAP CareSource conducts performance improvement projects (PIP) that focus on clinical and non-clinical areas. Below is a summary of project interventions in 2023.

Improving The Timeliness of Prenatal Care
HAP CareSource continued participation in the MDHHS PIP. The study indictor for the project is improving the Timeliness of Prenatal Care in the Black/African American Population. HAP CareSource will be measuring if targeted interventions increase the percentage of Black/African American women who receive a prenatal care visit in the first trimester, on the enrollment date, or within 42 days of enrollment into the MHP. HAP CareSource analyzes HEDIS results to measure the effectiveness of interventions and to identify additional opportunities for improvement.

PIP Results Remeasurement 1

Remeasurement period 1 is Measurement Year 2022 HEDIS® rate. The overall HEDIS® MY2022 prenatal care rate is 79.21% which is an increase of 3.41 percentage points compared to the baseline rate of 75.8%. HAP CareSource further compared the study indicator of the Black/African American remeasurement 1 rate to the baseline rare. The Black/African American baseline results are 157 out of 217 (72.35%) members received timely prenatal care compared to 148 out of 197 (75.13%) in remeasurement period 1. Utilizing the Chi-Square to analyze the data, the p value is 0.5217 and indicates the improvement in the rate is not statistically significant. HAP CareSource continues to identify opportunities for improvement and collaborate on plan interventions.

HAP CareSource has a prenatal care workgroup consisting of representatives from the Quality Management, Performance Improvement/HEDIS and Care Management departments. This workgroup

meets monthly to discuss ongoing barriers, interventions, and strategies to improve prenatal care. To identify initial barriers, the workgroup created and continues to utilize a fishbone diagram as a QI tool. This helped to document barriers and initiate discussions for improvement. Furthermore, workplans are maintained to track progress. Sessions were also held to brainstorm and prioritize barriers. Barriers were prioritized into focus areas. The workgroup completed the following activities throughout 2022/2023:

- Reviewing HEDIS® performance data
- Identifying key drivers and areas in need of improvement utilizing the fishbone diagram
- Identifying interventions to implement
- Developing action and work plans
- Monitoring intervention performance and outcomes
- Revise or discontinue interventions when necessary

Improving Well Child Visits in the First 30 Months of Life

The following Performance Improvement Project serves as the foundation of HAP CareSource's commitment to continuously improve the quality of the treatment and services it provides. HAP CareSource is committed to the ongoing improvement of services that are provided in a safe, effective, patient-centered, timely recovery-oriented fashion. HAP CareSource is committed to the ongoing improvement of the quality of care its consumers receive, as evidenced by the outcomes of that care. The organization continuously strives to ensure:

- The treatment provided incorporates evidence based, effective practices
- Providers are educated on the importance of preventive visits
- The treatment and services are appropriate to each consumer's needs, and available when needed
- Risk to consumers, providers and others is minimized, and errors in the delivery of services are prevented
- Procedures, treatments, and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care

Well-Child Visits in the First 30 Months of Life (W30) are important because it allows early intervention to increase overall wellness such as track growth and developmental milestones, complete preventive screenings and tests, and receive immunizations. Therefore, it is critical for children to complete well-child visits to serve the needs of children.

In addition to the clinical impact that W30 has, the sub-measures also have a significant impact on quality programs.

The (W30) 6+ Visits in First 15 Months measure is included in the following:

- Auto-Assignment
- Bonus Template
- Consumer Guide
- NCQA Accreditation

The (W30) 2+ Visits in between 15-30 Months measure is included in the following:

- Consumer Guide
- NCQA Accreditation

Measure Definition: The percentage of members who had the recommended number of well-child visits with a PCP during the appropriate age span. The following rates are reported:

1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.

2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Qualitative Analysis

HAP CareSource did not meet the MY 2021 NCQA Quality Compass 50th percentile goal for (W30) 6+ Visits in the First 15 Months or (W30) 2+ Visits in between 15-30 Months. However, HAP CareSource used the Chi-Square calculation to determine if these sub-measures had statistically significant improvement (where if the p-value <0.05 indicates statistically significant improvement). (W30) 6+ Visits in the First 15 Months performance rate increased by 16.38 percentage points from MY 2021 to MY 2022 and had a p-value = 0.00013 indicating statistically significant improvement. Additionally, the denominator increased from 208 to 389 members. The final (W30) 6+ Visits in the First 15 Months MY 2022 rate missed the goal of 55.72% by 3.28 percentage points (13 numerator hits) with a performance rate of 52.44%.

(W30) 2+ Visits in between 15-30 Months did not have statistically significant improvement. However, HAP CareSource had an improvement of 1.30 percentage points from MY 2021 to MY 2022. Additionally, the (W30) 2+ Visits in between 15-30 Months denominator increased by 304 to 509 members. The final MY 2022 performance rate missed the goal of 65.83% by 18.48 percentage points (95 numerator hits) with a performance rate of 47.35%.

HAP CareSource had two contractors conduct telephonic outreach in January - February 2022. The telephonic outreach focused on members who were due for well-child visits by the end of the year. Unfortunately, the contract for the telephonic outreach ended at the end of February. In October 2022, HAP CareSource brought back this telephonic outreach by hiring two (2) health outreach specialists who telephonically outreached to members that were due for well-child visits by the end of the year. During these outreaches, the health outreach specialists reminded members of the preventive care that they were due to complete, provide education around these services, identify, and address social determinants of health barriers, and assist in scheduling doctor appointments and transportation (as needed).

Quality Improvement Activities and Opportunities

- Revamped the reward program with the goal of increasing doctor office visits to increase the chance that preventive screenings and immunizations are completed during the doctor office visit.
- Continue to provide gaps in care information to providers to assist them in performing outreach

to their members and implementing member gaps in care via the provider portal.
- Created a health outreach team that focuses on getting 0–21-year-old members into the doctor's office.
- Create a postcard that will be delivered to members to remind members to schedule well-child visits.
- Continue focused member telephonic outreach including educational materials for members to inform them of the importance of well-child visits and to remind them of incentives and transportation opportunities.
- Continue to employ Alternative Payment Models and Value Based Payments within the HAP CareSource provider network.

Improving Lead Screening in Children

The following Performance Improvement Project serves as the foundation of HAP CareSource's commitment to continuously improve the quality of the treatment and services it provides. HAP CareSource is committed to the ongoing improvement of services that are provided in a safe, effective, patient-centered, timely recovery-oriented fashion. HAP CareSource is committed to the ongoing improvement of the quality of care its consumers receive, as evidenced by the outcomes of that care. The organization continuously strives to ensure:

- The treatment provided incorporates evidence based, effective practices.
- Providers are educated on the importance of preventive visits.
- The treatment and services are appropriate to each consumer's needs, and available when needed.
- Risk to consumers, providers and others is minimized, and errors in the delivery of services are prevented.
- Procedures, treatments, and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care.

Lead Screening in Children (LSC) can significantly impact a child's health by causing an increase in conditions such as learning and behavior difficulties, hearing and speech problems, and slowed growth and development. Lead exposure in children is often difficult to see and most children have no obvious immediate symptoms. Therefore, it is critical for children to obtain a lead screening, so high levels of lead can be identified early and treated.

In addition to the clinical impact that lead screening in children has, this measure also has significant impact on quality programs. The Lead Screening in Children measure is included in the following:

- Bonus Template
- Consumer Guide
- NCQA Accreditation

Measure Definition: Lead Screening in Children focuses on the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

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Qualitative Analysis

Unfortunately, HAP CareSource did not meet the MY 2021 NQCA Quality Compass 50th percentile goal of 63.99% with a performance rate of 48.74%. HAP CareSource missed the goal by 15.25 percentage points or by 92 numerator hits. Although there was not statistically significant improvement, HAP CareSource had an improvement of 4.15 percentage points from MY 2021 to MY 2022. In addition, the LSC denominator grew from 388 to 597 members from MY 2021 to MY 2022.

A couple of factors were identified that contributed to LSC not meeting the 50th percentile goal of 63.99%. The HAP CareSource MY 2022 performance rate continued to be affected by member disengagement with healthcare from the COVID-19 pandemic due to the two-year lookback period for LSC. Therefore, some members were not going into their doctor offices, specifically children who are deemed healthy. Additionally, there was a recall on lead screening tools, therefore doctors were not readily receiving strips that are required to complete lead screenings.

HAP CareSource implemented several initiatives to help improve the rate in MY 2022. HAP CareSource implemented a lead screening campaign to encourage providers and patients to schedule and complete a lead screening. Provider and patient outreach lists were sent out to targeted PO groups which included performance rates and member level detail information. Additionally, informative letters were faxed out to individual providers that included the patient information for who is missing a lead screening according to the most recent records.

Quality Improvement Activities and Opportunities

- Revamped the reward program with the goal of increasing doctor office visit rewards and increasing the chance that preventive screenings are completed during the doctor office visit.
- Included a $25 member reward for completing the lead screening.
- Provide gaps in care information to providers to assist them in performing outreach to their members and implementing member gaps in care via the provider portal.
- Created a health outreach team at the end of 2022 that focuses on getting 0–21-year-old members into the doctor's office.
- Create a post card that will be delivered to members to remind members to complete a lead screening.
- Create a lead screening fact sheet to display on the HAP CareSource website to educate members on the importance of lead screening.
- Continue to partner with provider groups to deliver outreach lists with member level detail and performance rates to encourage providers to schedule lead screenings with their patients.
- Continue focused member telephonic outreach including educational materials for members to inform them of the importance of preventive screenings and to remind them of incentives and transportation opportunities.
- Continue to employ Alternative Payment Models and Value Based Payments within the HAP CareSource provider network.

Activities Summary

A HEDIS® Outreach Team was established in August 2021 and conducted telephonic outreach to Medicaid

and MI Health Link members who needed preventive services. In Q1 2022, this team solely focused on outreaching to children who were aging out of Lead Screening (LSC), Childhood Immunizations (CIS), Immunizations for Adolescents (IMA) and/or Well-Child Visits within the First 30 Months of Life (W30) by August 2022. These measures were the focus as they saw significant decline throughout the pandemic. Throughout the outreach, the team also addressed social determinants of health barriers that were identified.

In addition to telephonic outreach, HAP CareSource implemented quarterly text messaging campaigns for Women's Preventive Health and Child/Adolescent Well Visits. Measures that were specifically targeted included: Chlamydia Screening in Women (CHL), Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS) as well as Child and Adolescent Well-Care Visits (WCV).

HAP CareSource also enhanced the Member Rewards Program to make it less burdensome, moving it from a form-based program to a claim-based program. The 2022 Member Reward Program did reward members for completing a number of preventive services, which are listed below:

- Childhood Immunizations – Combo 3 (CIS)
- Immunizations for Adolescents – Combo 2 (IMA)
- Lead Screening in Children (LSC)
- Child and Adolescent Well-Care Visits (WCV)
- Well-Child Visits within the First 15 Months of Life (W30)
- Breast Cancer Screening (BCS)
- Chlamydia Screening in Women (CHL)
- Prenatal Visit (PPC)
- Postpartum Visit (PPC)
- Diabetic Eye Exam (CDC)
- Adult Access to Care: 20-44 Year (AAP)
- Healthy Michigan Dental Visit

HAP CareSource's Community Outreach Team established a close partnership with the Detroit Health Department where a number of clinical events were conducted throughout the summer of 2022 with the sponsorship and assistance of the Detroit Public Schools. The focus was to provide both HAP CareSource Medicaid Members as well as community members with various immunizations (i.e., childhood immunizations, immunizations for adolescents, and COVID-19 immunizations) as well as lead screenings.

Barriers
Some barriers that were identified throughout 2022 include:

- A lack of a strategic and consistent communication plan that encompassed all member communications (email, text, mail, telephonic). This also led to concerns around burdening the member with a number of repetitive or conflicting messages, which could negatively impact member experience and lead to disengagement.
- HAP CareSource has not been able to send out text messages for members that are 0-17 years old as that data is still being mastered.
- 2022 was a transition year for the Rewards Program, meaning some rewards still follow the

manual reporting process and the automation process is split across multiple teams.
- For 2022, some of the member rewards were not incentivizing members to complete the service as the incentive amount did not match the amount of visits that the member was required to complete. (For example, members had to complete 6 well-child visits by their 15th month birthday in order to get their $50 incentive)
- HAP CareSource saw low show rates at the clinic events, even with reminder calls and appointment confirmation letters

We Treat Hepatitis C Initiative

HAP CareSource partners with the MDHHS public health campaign called *We Treat Hep C*, aimed at eliminating Hepatitis C Virus (HCV) in Michigan. The initiative involves increasing the number of people who are tested for HCV, increasing the number of providers who treat HCV, and expanding access to HCV curative treatments. Below are the care coordination activities focused on HCV during 2023.

- A workgroup meets monthly to review the internal workplan, implement interventions from the *We Treat Hep C* Care Coordination Memo and discuss any barriers as needed. The workgroup is comprised of stakeholders from Care Coordination, Quality Management, Pharmacy, and Provider Network Management teams.
- ***Member Outreach***
    - HCV letter template and fact sheet sent to all members ages 18 and older with quarterly mailings scheduled for new members
    - Utilizing CHWs, Community Based Organizations and homeless shelters to conduct outreach to beneficiaries that are transient/difficult to reach, including those who are homeless, disabled or those living with substance use disorders
    - Developing a report of members with an HCV diagnosis and without a record of treatment to conduct ongoing outreach
    - Follow-up with members who have a positive HCV test as well as their providers to initiate treatment with Mavyret
    - Utilizing the Daily Carve-Out Utilization File (5165), regarding members who are receiving Mavyret or another DAA to conduct outreach to members receiving treatment and provide education on medication adherence
- ***Provider Outreach***
    - A Hepatitis C provider resource page was added to the HAP CareSource website
        - Education materials to network providers on the CDC's new universal testing guidelines
        - Promoting the resources listed on Michigan.gov/WeTreatHepC.
    - Work with providers to incorporate orders for HCV tests in routine primary care for all members
    - Ensure that CDC HCV testing algorithms are followed (running an HCV virus detection test or PCR for any persons who tests positive for HCV antibody)
    - Conduct targeted outreach and support to network providers in areas where HCV is prevalent as well as to network providers who treat opioid use disorder
    - Promote medication adherence to network providers and pharmacies to ensure that Mavyret is dispensed in an 8-week supply (or 12-week supply when appropriate)
    - Encourage providers to enroll patients receiving treatment in the Mavyret Nurse Ambassador program.

- ***Pharmacy Outreach***
    - Provide ongoing education to network pharmacies s including the removal of prior authorization requirement for Mavyret

Pediatric Sickle Cell Quality Collaborative
HAP CareSource partners with MDHHS on a pediatric sickle cell quality improvement project to improve care by preventing serious infections, stroke, and pain crises among children with sickle cell anemia. The quality collaborative will combine the collective knowledge and lived experiences of parents and individuals with sickle cell disease, in partnership with the University of Michigan, the state of Michigan, and Medicaid Health Plans in Region 10 to implement a pilot Pediatric Sickle Cell Improvement Program in Southeast Michigan.

This program aims to achieve improvement in preventive care delivery for this high-risk and vulnerable population through the development of an innovative quality collaborative that will have Medicaid Health Plans working together as one team to improve the care of all children with sickle cell in the region, not just those enrolled in their individual plans. This initiative will develop a robust platform for interaction to share ideas and provide support as the health plans work together to improve the performance rates of antibiotic prophylaxis, transcranial Doppler screening, and hydroxyurea use.

***Preventive Care Outcomes Measures for Children with Sickle Cell Anemia*:** The following quality measures will be utilized and have been endorsed by the National Quality Forum.

- **Daily Antibiotics Dispensed**: Increase the percentage of children ages 3 months to 5 years who are dispensed appropriate antibiotic prophylaxis for at least 300 of 365 days per year.
- **Annual Transcranial Doppler Ultrasonography (TCD) Screening**: Increase the percentage of children ages 2 through 15 years old who receive at least one TCD screening per year.
- **Daily Hydroxyurea Dispensed**: Increase the percentage of children ages 1 to 18 years who are dispensed hydroxyurea for at least 300 of 365 days per year.

Below data shows measurement period performance for 7/1/22 – 6/30/23 for Region 10:

REGION 10 Only Pediatric Members with SCA	Numerator (N)	Denominator (D)	Rate (N/D)
Proportion of pediatric members (ages 2 through 15 years) with sickle cell anemia with a completed transcranial Doppler (TCD) screening	6	11	54.54%
Proportion of pediatric members with sickle cell anemia (ages 3 months to 5 years) with at least 300 days of dispensed antibiotics	1	2	50%
Proportion of pediatric members (ages 1 to 18 years) with sickle cell anemia with at least 300 days of dispensed hydroxyurea	2	14	14.3%

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Population Health Management

The Population Health Management (PHM) Strategy outlines HAP CareSource's comprehensive and integrated programs that address population health management. HAP's approach to managing population health ensures that members' needs are being met across the continuum of care to ensure that they have access to high-quality, cost-effective health care. The strategy is a framework that defines how health services are offered and delivered to meet the needs of HAP's members across the four focus areas of population health, including:

- Keeping Members Healthy
- Managing Members with Emerging Risk
- Patient Safety or Outcomes across Settings
- Managing Multiple Chronic Illness

Annually, HAP CareSource reviews member population data through a combination of reports on characteristics, including demographics of HAP CareSource membership. This analysis of data includes a review of:

- Characteristics and needs, including social determinants of health
- Relevant subpopulations and subpopulation needs, examples:
    - Multiple chronic conditions
    - At-risk ethnic, language and/or ethnic groups
- The needs of children and adolescents
- The needs of individuals with disabilities
- The needs of individuals with serious and persistent mental illness

A regional and statewide population review is also performed to determine health disparities and other potential population issues that may need to be addressed for the HAP CareSource membership. Following this analysis, findings are used to:

- Identify changes to business rules which will better identify individuals for PHM programs, including but not limited to, the number of events (hospitalizations and ER visits) used to flag potential PHM program candidates; the cost threshold levels; which diagnosis or procedure codes are used to target members; and the risk score ranges or other new methods to consider when identifying potential PHM candidates
- Review and identify changes to PHM processes to best address member needs. The business drivers for these changes include but are not limited to, compliance with mandatory regulations, reduction of redundant member outreach; continuous improvements including clinical effectiveness, outcomes and quality, and increased coordination across programs
- Review PHM resources and modify them, if necessary, to address member needs

Annually, a comprehensive analysis inclusive of clinical, cost/utilization and experience measures are completed to evaluate the effectiveness of the PHM programs and the overall impact of the PHM strategy. Specific measurements included in the annual analysis are included in the *Annual Population Health Management Impact Measures*. This analysis was conducted by the supporting departments and reviewed and approved by the CQMC. After the completion of the analysis, the PHM workgroups will modify the strategy document, as necessary, to reflect any changes that need to be made based on the evaluation and the population assessment

Once the population analysis is complete, the results of the population assessment analysis are used to determine whether the PHM Strategy meets member needs. The following components are evaluated for necessary updates:

- PHM programs, services and activities
- PHM staff resources and training
- Community resources

Data/Risk Stratification

Data integration allows for member identification as well as determining and supports their ongoing care needs. HAP may evaluate a number of integrated data sources to determine the appropriate risk stratification of members including those that offer predictive modeling to ensure that me members receive the appropriate support and interventions in the right setting at the right time. HAP's segmentation and stratification process utilizes the ACG process to group and segment the entire membership appropriately utilizing a predictive risk stratification modeling system. This system assigns each member into one of six segments and then calculates member risk scores within each segment. The tool provides in-depth data analytics, interpretation and customization of population health data paired with design and implementation of care management plans and clinical interventions programs to meet the unique needs of varying populations.

Care Coordination

HAP CareSource continues to assist those members with the most acute physical and socioeconomic needs through their Complex Case Management program. This program is available to members with multiple chronic illnesses, chronic illnesses that result in high utilization, or a new diagnosis of certain diseases. The nurse case manager completes a comprehensive assessment on the member's conditions, medical history, and medications in order to better determine how to assist the member in regaining optimum health. All members enrolled in Complex Case Management are also referred to a social worker for further evaluation and discussion of their needs.

The purpose of HAP's Care Management program is to improve the health and well-being of its membership by addressing the medical, pharmacy and psychosocial needs of members. Care Management team members optimize the use of community resources and work to strengthen the member's relationship with the practitioner and care teams. Care management programs are integrated with Utilization Management through a concurrent review process which results in a referral to Care Management for members who meet program criteria

The Care Management programs provide care coordination across all settings, including acute outpatient and inpatient. HAP provides Care Management services both within the service area and to members who are traveling or residing out of area. Members identified as at risk for safety and symptom management related to medication are referred to HAP's Pharmacy department for a medication management evaluation.

An important part of each program is the ability to share information electronically. CareRadius functions as both a care coordination platform and a communication mechanism that enables staff to see all the programs and services a member receives. CareRadius is designed with a member centric

approach that allows each discipline to review other disciplines' documentation and updates. Tasking and other forms of communication within the platform complement face to face and email communication between staff members. Within the 360-view in CareRadius, all programs are listed for all Care Radius users. Within the conditions/risks screen, all conditions are listed from claims and the ACG tool. The CareRadius Manual identifies each category in the 360 View: Participation & Recruitment, Risks and Conditions, Care Alerts, Metrics and Labs, Medications, Utilization Management (UM) Summary and Eligible Services. A Care Alert is created for members with the following conditions: HTN, COPD, DM, and CHF to coordinate care. With the multi-disciplinary approach CareRadius provides each team, it allows each discipline to review all documentation and updates and allows for enhanced communication of member conditions.

The SDoH/Population Health Strategy Plan for all members is focused on our responsibilities to integrate clinical and social health. We are committed to assessment of members, connecting them to community resources and implementation of clinical and community wide projects and initiatives. We have developed analytics that will assist us in continuous evaluation of this project and include metrics encompassing the impact of unequal distribution of health damaging experiences for our members. HAP will continue its partnership with EXL to integrate risk stratification and member analytic capabilities into care coordination tools and processes to identify and engage with higher risk members. The new platform will also have a member 360 view that will integrate member SDOH, barriers, and top interventions allowing HAP to leverage care coordination resources most effectively.

Informing Members

HAP has a summary that is posted in a central location that is accessible for current and prospective members that describes all available Population Health Management programs. Information is located on HAP's website for Medicaid members under the health programs tab. Additional information about Population Health Management Programs is contained in member handbooks.

Social Determinants of Health

The SDoH screening, assessment, and referral data is stored in CareRadius, which is the case management system that stores all documentation. The Case Management team attempts to complete a SDoH screening for new members during the New Member Screening outreaches. These outreaches are conducted during the first 90 days of enrollment in the HAP CareSource Medicaid plan. SDoH screenings for existing members are completed by the Case Management Social Work and/or CHWs teams for members referred to the case management department for an SDoH need. Referrals might come from discharge reports for general case management follow up or the Vantage Risk scoring tool as a high-risk member potentially eligible for complex case management.

During the SDoH outreach call, the case manager documents information including the survey creation date, member's name, and whether the member is willing to complete the survey. When the member agrees to complete the survey, the case manager asks the member questions that cover many SDoH domains, including food, housing, utilities, employment, and transportation. The case manager also asks if the member would like to receive assistance with each SDoH domain assessed. Referral tracking data is collected, including member acceptance or refusal of any referrals made and member satisfaction

with any referrals. The date the survey was completed is also included to provide a time marker if future follow-ups are conducted. HAP is able to download SDoH assessment and screening data in real time.

HAP's provider-initiated screening data is stored in Milliman MedInsight, an analytics company that is the main vendor for claims data for HAP. The provider-initiated data is obtained by selecting desired fields such as admit date, ICD diagnosis code, billing provider name, and specifying the date range. SDoH domains are obtained by grouping the ICD diagnosis codes into the respective SDoH categories in accordance with the Mapping Z codes tab of the FY23 MHP SDoH Screening Template. Since this report contains claims data, there can be a data lag of 1-3 months. The plan utilizes claims reporting that feeds into Power BI visualizations to monitor the usage of Z codes by providers. The plan works with providers to increase the usage of appropriate Z codes through check-ins and alerting when major discrepancies or observations are noted. The four most common Z codes utilized by our providers are: Z23 (Encounter for immunization), Z608 (Other problems related to social environment), Z558 (Other problems related to education and literacy), and Z638 (Other specified problems related to primary support group).

HAP CareSource takes a multimodal approach when working with our members to address population health. Prevention health and wellness outreaches could be completed through traditional mail, telephonic, text, email, IVR, and online platforms. HAP CareSource also offers language line/interpreter services as well as materials in TDY, braille, and large print. This multifaceted approach to member outreach allows for increased member touches, ensures the ability to provide health information at the appropriate acceptable reading level to encourage and support improved health literacy.

Integration of Behavioral Health and Physical Health Services

HAP CareSource coordinates care provided to members with the Prepaid Inpatient Health Plans (PIHP)that manage services for those individuals. It is further the policy of HAP CareSource to work cooperatively with other PIHPs to jointly identify priority need populations for purposes of care coordination. Ongoing activities are noted below:

- At least monthly, identify which members are assigned to an MHP and have sought services through the PIHP
- Quarterly, demonstrate that joint care plans exist for members with appropriate severity risk that have been identified as receiving services from both HAP CareSource and the PIHP
- Participate in the MHP-PIHP Workgroup. Activities include:
    - Enhancements to CC360 to streamline member search and risk stratification
    - Working to add homeless indicator and homeless vulnerability score to CC360
    - Worked to develop at least two standard of care protocols for care coordination as identified collaboratively with MDHHS
- Completed data validation for the following performance measures with the shared metrics with the PIHPs: Plan All-Cause Readmissions (PCR) and Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)
- Participate in MiHIN (Michigan Health Information Network)
- Establish and implement joint care plan management standards and processes to ensure appropriate communication exists and enough efforts are being made to support success in integration. The joint care plans will foster an environment of collaboration between HAP CareSource and the PIHPs for the ongoing coordination and integration of services

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Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member Survey Results

Press Ganey, a Centers for Medicare and Medicaid Services (CMS) certified Survey Vendor, was selected by HAP CareSource Medicaid to conduct its 2023 Medicaid CAHPS* Survey.

Survey Objective:

The overall objective of the CAHPS* study is to capture accurate information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their member's expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement.

The 2023 Medicaid Adult 5.1H CAHPS surveys were collected via a mail and phone methodology. Members eligible for the survey were those 18 years and older (as of December 31 of the measurement year) who were continuously enrolled in the plan, allowing for one gap of up to 45 days during the measurement period.

The following survey results are compiled from the 183 HAP CareSource Medicaid members who completed the survey, for a response rate of 10.5%.

MEASURE	SUMMARY RATE		CHANGE	2023 PG BOOK OF BUSINESS BENCHMARK		
	2022	2023		PERCENTILE DISTRIBUTION	PERCENTILE RANK	BoB SRS
Health Plan Domain						
Rating of Health Plan *% 9 or 10*	64.2%	63.9%	-0.3		54th	63.6%
Getting Needed Care *% Usually or Always*	80.9%	80.5%	-0.4		38th	82.0%
Customer Service + *% Usually or Always*	91.6%	90.3%	-1.3		53rd	89.8%
Ease of Filling Out Forms + *% Usually or Always*	96.3%	97.1%	0.8		87th	95.3%
Health Care Domain						
Rating of Health Care *% 9 or 10*	59.3%	57.1%	-2.2		53rd	56.8%
Getting Care Quickly *% Usually or Always*	85.2%	78.7%	-6.5		30th	81.5%
How Well Doctors Communicate + *% Usually or Always*	95.4%	93.3%	-2.1		55th	92.8%
Coordination of Care + *% Usually or Always*	84.9%	86.7%	1.8		56th	85.6%
Rating of Personal Doctor *% 9 or 10*	72.7%	71.0%	-1.7		64th	69.2%
Rating of Specialist + *% 9 or 10*	67.8%	63.1%	-4.7		28th	67.4%

Performance Summary

- All measures fell below the 67th percentile.
- Low performing measures were:
  - Getting Care Quickly
  - Rating of Specialist

CQMC: 2/20/2024

    - Getting Needed Care
- Those with Fair/Poor health rate their personal doctor significantly lower, but rate getting care quickly higher.
- Black/African Americans rate their specialist higher than White/Caucasian.
- Significant increase in percentage of respondents who are 18-34, with comparable drop-off in 55+ age group.
- Areas of opportunity: Rating of specialist, Getting care, tests, or treatments, Treated with courtesy and respect, Getting urgent care, Getting specialist appt., Dr. spent enough time

Provider Satisfaction

HAP CareSource annually conducts a Provider Satisfaction Survey to assess the strength of their relationship with providers in the plan and to identify areas of improvement. Providers in HAP CareSource's network are surveyed for satisfaction in the following areas:

- Provider Relations
- Network
- Utilization Management
- Quality Improvement
- Finance Issues
- Pay for Performance bonus programs
- Pharmacy and Drug Benefits

Objectives

This annual research effort seeks to obtain an understanding of overall satisfaction among provider practices within the network, with the following objectives:

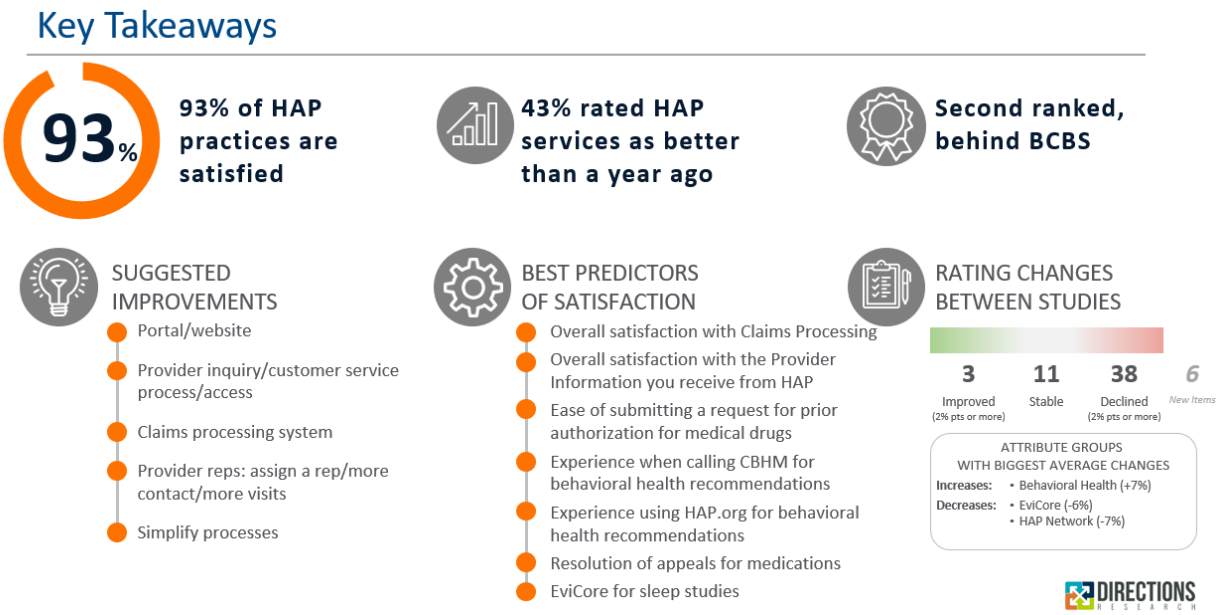
- Assess and monitor provider practice satisfaction
- Identify opportunities for HAP to improve services to provider partners
- Provide data to support and develop internal stakeholder initiatives

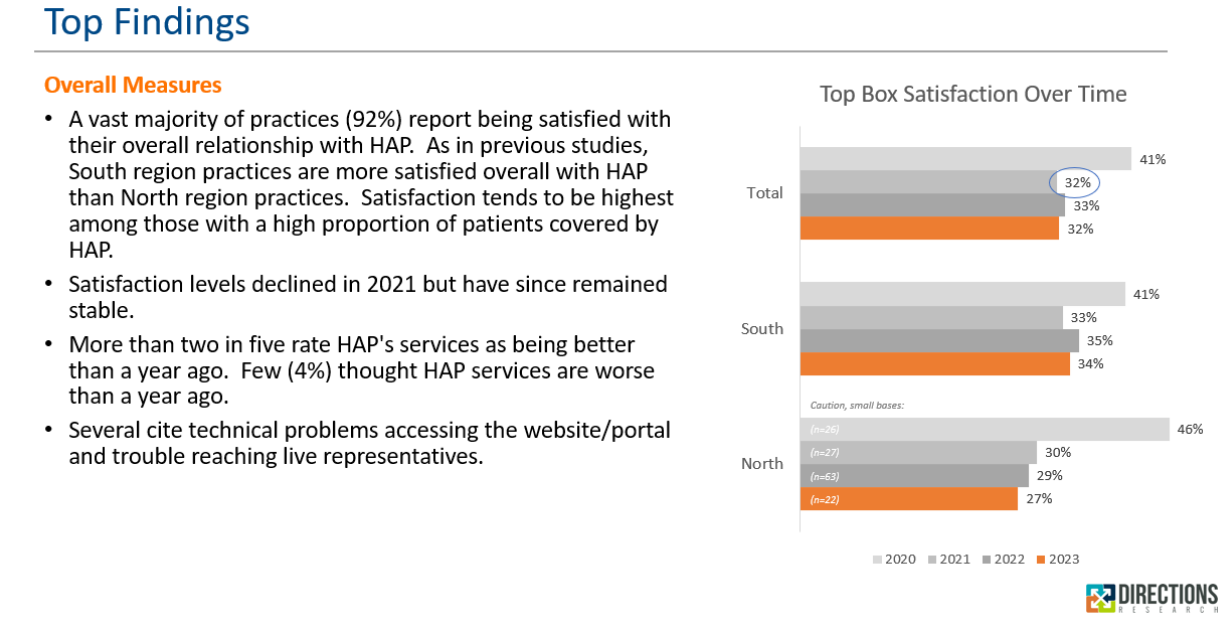
Methodology

- The 2023 methodology focused on emailed survey invitations. HAP provided email addresses for some practices, and Directions Inc. appended emails for additional practices based on calling results from previous research conducted on HAP's behalf in 2022. The appended information increased the proportion of practices with an associated email from an initial 555 (40% of 1402 records) to 945 (67%). Practices were sent an email invitation to participate in the survey by web.
- Initial telephone calls were placed concurrently with email invitations to encourage participation. During the course of telephone contacts, additional email addresses (~135) were collected, and survey invitations were emailed. In total, 1000 practices (71%) were emailed survey invitations, some at multiple addresses.
- All practices who did not respond to the email inquiries were mailed a packet in mid-September including a survey, cover letter, and return envelope. Instructions were given on how to complete surveys by mail, web, or phone.
- The mailing included a unique six-digit identification number that was used to track participating practices.

- Follow-up telephone calls were placed concurrently with reminder email invitations to encourage participation by mail or web. Fax surveys were not offered in 2023. Up to five phone calls were placed to each practice to encourage participation.
- Survey results were collected between August 30 and November 15, 2023.
- The results in this report reflect only those from the 113 HAP CareSource practices, defined as any designated as accepting Medicaid or MMP patients.

2023 Provider Satisfaction Results





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Patient Safety/Quality of Care

HAP CareSource addressed patient safety during 2023 in a variety of areas, including:

- Maintained oversight of regulatory guidelines from the Centers for Medicare and Medicaid Services (CMS) and to apply updates to HAP processes for compliance with monitoring health care acquired conditions.
- Maintain an ongoing process to monitor and investigate hospital-acquired conditions (HACs) and provider preventable conditions (PPCs).
- Promoted increased awareness and safe working conditions by collaborating with the Building Operations team.
- Identified HACs and PPCs through DRG-based audits conducted by HAP's vendor, Change Healthcare, Power BI claims data associated with HACs, and quality referrals from the provider appeals, inpatient admissions, case management, and high-cost review teams where access to clinical notes allows identification of potential issues.
- Continued to monitor and track HACs and PPCs to identify trends of potential quality concerns at HAP-contracted health systems and associated hospitals. The Peer Review Committee (PRC) reviews all cases flagged with claims associated with HAC 01 (Foreign Object Retained After Surgery) and reports its findings to the Quality and Safety Committee (Q&S Committee) for disposition.
- The Peer Review Committee reviewed and discussed all cases involving members who had claims associated with HACs to determine whether withholding monies for services rendered was warranted for reporting to the U.S. Office of Inspector General (OIG) Annual Integrity Report and referred those cases to the Q&S Committee for disposition.
- Continued strong collaborative association with HFH Director of Performance Excellence and Quality regarding process improvements to decrease quality concerns.
- Participated in the ongoing community Michigan Health and Hospital Association, Quality Improvement Directors' meetings, and other forums to address and support quality and safety improvement initiatives locally and statewide.
- Continued participation in the Michigan Quality Improvement Consortium (MQIC) to promulgate evidence-based medicine, preventive services, health promotion, disease management programs, and clinical practice guidelines to practitioners in Southeast Michigan and for use by HAP.

Customer Service Call Center Utilization & Responsiveness

Workforce management and customer service work together to monitor our metrics (number calls received, average speed to answer and abandonment rate). The workforce management uses historical data to predict future staffing needs. The workforce management team creates schedules that best fit the forecasted model to make sure that we have enough staff for the predicted calls. Forecasting is anticipating call volume based on historical trends, current trends, and business insights. Reports are also created to view historical trends across a variety of key indicators. The team monitors and tracks queue level performance which includes tracking agents' activities in real time. Real time management is the process of monitoring call center Key Performance Indicators (KPI's) and agents in real time statuses so that adjustments can be made to meet the department's service level goals. In addition to monitoring and forecasting trends both teams meet regularly to discuss the forecast and real-time data to make updates as needed. The workforce management and customer

service are in constant contact with each other to make sure that we are aligned with how to handle operations day-to-day. The table below displays 2023 metrics. The disconnect rate is the *abandonment rate* and average hold time to connect to agent (seconds) is the *average speed to answer.*

2023 Consumer Operations Key Compliance Metrics Dashboard

	COMPLIANCE GOAL	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
I	CMS CALL PROCESSING												
4	Phone Performance - Medicaid Only (Hap Empowered/Midwest)												
	Incoming Call - Volume	3,632	3,101	3,617	3,148	3,392	2,673	2313	2626	2512	1343	1080	849
	Disconnect Rate - Incoming Calls	1%	1%	1%	1%	2%	1%	2%	3%	5%	5%	2.8%	5.2%
	Service Level	89%	92%	91%	93%	93%	94%	84%	81%	73%	78%	84.3%	72.3%
	Average hold time to connect to an agent	26	18	20	20	19	15	24	39	58	44	30	55

Quality Evaluation Summary

Overall, HAP CareSource has made progress in improving the quality of care, safety, and service to our members. We continue to work with our providers to educate and provide access on the web site for the following:

- Communications (administrative manual, newsletters, etc.)
- Quality Program Documents
- Provider and staff directories
- Forms and resources
- Pharmacy and formulary
- Privacy practices
- Member eligibility
- Claims/appeals
- Clinical practice guidelines
- Member roster
- Authorizations/referrals

HAP CareSource has improved member experience, care coordination, community outreach and member services. Throughout 2023 there have been continuous enhancement in the structure for the Medicaid improvement efforts including:

- Holding monthly interdepartmental team focus on Medicaid initiatives aimed at improving HEDIS/CAHPS measures
- Monitoring monthly HEDIS rates progress toward goals through the Medicaid dashboard
- Maintaining and revising the Medicaid Initiative Work Plan focused on improving HEDIS and CAHPS rates
- Working with Provider Network to identify quality measures for the Provider Best Practice Program

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2024 Initiatives

- Quality Program Performance*:*
  - Maintain HEDIS, CAHPS and NCQA® plan rankings
  - Achieve band 2 status for Medicaid Auto Assignment
  - Attain the Michigan state average for the Medicaid Consumer Guide
- Address social determinants of health, and initiate efforts to reduce racial and ethnic disparities with a focus on existing disparities in access to healthcare and health outcomes through ongoing interventions in support of Quality Improvement Projects (QIP) and Performance Improvement Projects (PIPs)
- Maintain a Population Health approach in providing integrated, interdisciplinary care coordination at HAP across all clinical settings and members' circumstances optimizing the use of community resources
- Address Purchaser, Accreditation and Regulatory requirements as evidenced by achieving NCQA Health Plan accreditation
  - Maintain Health Plan Accreditation
  - Maintain LTSS Distinction
  - Maintain MED Module Accreditation
  - Obtain Health Equity Accreditation
- HAP Provider Network Performance is optimized to support members based on value driven care, clinically appropriate utilization, and high-quality population outcomes
  - Monitor over and underutilization of services
  - Provide monthly HEDIS reports to participating POs
  - Alternative Payment Model
- Review, investigate, and monitor concerns regarding affiliated providers which have the potential to negatively affect the quality, safety or integrity of services rendered to members and to determine appropriate follow-up as necessary.
- Evaluation of the Quality Program Activities as evidenced by completion of the annual evaluation of the Quality Program, Work Plan, and Quantitative Assessment
- Continue efforts toward maintaining regulatory, State, and CMS compliance
- Continue to identify health disparities and implement interventions to reduce racial/ethnic disparities in care
- Monitor and track performance monitoring standards for the following measures:
  - Healthy Michigan Plan (HMP) Cost Sharing and Value-based services Measures
  - MDHHS Dental Measures
  - CMS Core Set Measures / HEDIS / Managed Care Quality Measures
  - Maternal Health Measures
  - Chronic Conditions Measures
- Continue collaboration on the following quality improvement projects:
  - Low Birth Weight
  - Pediatric Sickle Cell
  - Hepatitis C
  - Population Health Management:
    - Social Determinants of Health
    - Pregnancy Management Measures
    - HIV Provider Outreach

        - LGBTQ+ Care
    - Integration of Behavioral Health
- Promote Coordination of Medical and Behavioral Health care
    - Collaborate between pre-paid Inpatient Health Plans (PIHPs) and HAP CareSource teams.
    - Continue to access data on joint members, develop joint care management standards and processes, and implement joint care managements processes.
    - Continue monthly meetings to review high risk members
    - Continue bi-monthly meetings with the PIHPs; MHPs; and MDHHS for the purpose of improving coordination processes'
    - FUH and FUA measure performance improvement initiatives